## HORMONAL METHOD EVALUATION ORAL CONTRACEPTIVES (Combined and POP), EVRA PATCH, NUVARING, IMPLANON (rod implant)

Name		Today's date Age	
	Please check your current method		
	<ul><li>☐ Birth control pill (Combined)</li><li>☐ Evra</li><li>☐ Implanon</li></ul>	<ul><li>☐ Birth control pill (Progesterone only)</li><li>☐ Nuvaring</li></ul>	
2.	Are you having any problems with your method? ☐ No ☐ Yes Explain:		
3.	Do you have any questions?   Explain:		
4.	Have you had any health problems or seen a physician since your last visit?  ☐ No ☐ Yes Explain:		
5.	Are you taking any other medication		
6.	Check if you have had any of the fo	ollowing since you started your method:	
	<ul> <li>□ Severe headaches</li> <li>□ Dizziness</li> <li>□ Vision changes</li> <li>□ Chest pain</li> <li>□ Severe leg pain</li> </ul>	<ul><li>☐ Severe abdominal pain</li><li>☐ Depression</li><li>☐ Nausea or vomiting</li><li>☐ Heavy bleeding</li><li>☐ Weight gain</li></ul>	
Clie	ent Signature	Date	
то	BE COMPLETED BY STAFF		
S:			
0:	B/P WT		
A:			
P:			
Sta	ff signature	Date	